Joint TP/TLM Group meeting – Thursday 03 March 2016

NHS Blood & Transplant Office
- 65 New Street – Birmingham - Conference Suite – Room 2
Action / Summary Log

Transfusion Practitioner Attendees	**Transfusion Laboratory Manager Attendees**
Angela Sherwood, Chair, University Hospitals Coventry & Warwickshire NHS Trust Suzy Biggs, RTC Administrator, NHS Blood & Transplant Julie Buchan, Burton Hospitals NHS Foundation Trust Mary Blanton, The Royal Wolverhampton NHS Trust Michelle Budd, University Hospital Birmingham NHS Foundation Trust Debbie Clinton, Worcester Acute Hospitals NHS Trust Karen Cooper, Shrewsbury & Telford Hospitals NHS Trust Mandeep Dhanda, Walsall Healthcare NHS Foundation Trust Gill Godding, Worcester Acute Hospitals NHS Trust Alister Jones, Secretary PBM Regional Lead NHS Blood & Transplant Clare Pedley, Birmingham Children's Hospital NHS Foundation Trust Alex Radford, Robert Jones & Agnes Hunt Orthopaedic Hospital Caroline Tuckwell, The Dudley Group Of Hospitals NHS Foundation Trust Antoinette Turner, University College London Hospital NHS Trust Madeline Wheeler, The Dudley Group Of Hospitals NHS Foundation Trust	Mike Herbert, Chair, The Royal Wolverhampton NHS Trust Gregory Barber, Heart of England Foundation Trust Fay Birch, Spire Parkway Chhaya Buffey, Spire Little Aston Richard Cole, Birmingham Children's Hospital Foundation Trust Phillippa Cheshire, Worcestershire Acute Hospitals NHS Trust Paul Fleetwood, Birmingham Women's Hospital Foundation Trust Aleta Lawley, Nuffield Hospital Cathy Lim, NHS Blood & Transplant Jenny Meredith, Heart of England Foundation Trust Gurjit Pahal, Walsall Healthcare NHS Foundation Trust Jan Shields, Shrewsbury & Telford Hospitals NHS Trust Anna Smith, The Royal Wolverhampton NHS Trust Jenny Smith, Spire Little Aston Mike Taylor, Shirewsbury & Telford Hospitals NHS Trust Tina Taylor, University Hospitals Coventry & Warwickshire NHS Trust Alison Watt, SHOT, NHS Blood & Transplant Paul Whittaker, University Hospital Birmingham NHS Foundation Trust Craig Wilkes, NHS Blood & Transplant

Topic / Presented by who :	**Discussion / points raised by who:**	**Action required by when & who:**
Cold Chain Regulations – where are we now? ***Alison Watt*** *Operations Manager* *Serious Hazards of Transfusion (SHOT)*	• Recognised that there are grey areas concerning the period of time the unit is transfused over. • RBC transfusions exceeding 5 hours are reportable to SHOT. Although difficult to determine if the transfusion actually took that long or whether the ward forgot to end the transfusion on the system. • If a unit is a taken out and then placed in quarantine it most likely won't be reported as no risk of harm to the patient. However, if the unit was returned to stock it would be reported as a near miss. • May be reportable to MHRA as they will be interested in your local quality system. • When looking at studies that the cold chain regulations are founded on, these are weak studies. • Work is currently being done in the component development department which has shown the quality of red cells were not affected if the sample was left out in room temperature for over 30 minutes.	

	• Discussed HEV and SHOT reporting. If the hospital has performed local risk assessments and the decision has been made to not adhere to the HEV recommendations then it will not be reportable. • Only reportable if HEV neg was not given by accident (specific requirements not met).	
Hepatitis E Virus and blood components ***Dr Suzy Morton*** *Consultant in Transfusion* *NHSBT and University Hospitals Birmingham NHS Foundaton Trust*	• SM mentioned that there may be a SHOT grace period to allow hospitals to implement procedures and protocols and roll out training. • HEV also applies to plasma and cryoprecipitate. • Labs are finding it difficult to engage with other teams outside of haematology. • Suggestion for the solid organ transplant communication to be driven by the transplant team. Emails and letters can be cc'd to the transfusion teams from the transplant team. • Not possible to rely on serology as past infection doesn't necessarily mean that the donor or patient will not be HEV viraemic on another occasion. • AJ asked about ordering irradiated stock as HEV neg as well – majority of hospitals confirmed that they would like to do so. • SM asked how many hospitals would be following the SaBTO recommendations – all hospitals present stated that they would follow the recommendations. • HEV positive donors will be deferred for 6 months, given an information leaflet and supported with clinical advice via telephone conversation.	
RePHILL study ***Mike Herbert*** *Transfusion Laboratory Manager/Deputy Head BMS* *Royal Wolverhampton Hospitals NHS Foundation Trust*	• GG from WorcsAcute and AT from University Hospital London that whilst on the air ambulance, giving saline which was too cold could potentially create additional problems for patients. • MT from Shrewsbury asked who was responsible for the traceability. It was thought the receiving hospital should be and it was recommended that the paperwork to transfer the unit of blood to the hospital could accompany the units of blood and be completed retrospectively. • Dr Heidi Doughty and Jane Tidman were working on this currently and when information is available, MH will share it with the group. It is hoped that roll out will be soon.	**Action: MH will share Documents when Available from HD**
Audit update	• Out of hours transfusion - CMT said we would set a time period rather than a number of cases. It would include an organisational survey and overnight issues. This will roll out in April. • Albumin Survey – Usage has gone up in a number of hospitals, however, due to a very poor response from TLMs on a survey monkey - (4 said "no" to a survey 1 said "yes") this will be placed on the back burner.	**Action: All Apr 16**

Wrong Blood in Tube audits ***Caroline Tuckwell*** Transfusion Practitioner Dudley Group NHS Foundation Trust	• The report recommends all WBITs should be classed as a Near Miss Never Event • Hospitals should follow BCSH *Guidelines for Pre-transfusion Compatibility Procedures in Blood Transfusion Laboratories (2012)* - secure electronic patient identification systems are in place, a second sample should be requested for confirmation of the ABO group of a first time patient prior to transfusion (but not impede the delivery of urgent red cells or other components). • There should be a hospital policy for the identification and communication of identified WBIT events across pathology. • All identified WBITs must continue to be reported to SHOT. • WBIT incidents should be investigated proportional to the event (as advised by the HTT) using appropriate RCA techniques. Staff using these techniques should be trained in their use. • Subsequent actions should relate to the identified root causes. Re-training and re-assessment are not always adequate actions following a WBIT error. • The West Midlands RTC should adopt the London TP Group's Top 10 tips for improving sample collection and labelling practice.	
NHSBT Customer Service updates ***Alister Jones & Cathy Lim*** *PBM Practitioner & Customer Services Manager* *Hospital Liaison Team – NHSBT*	<u>Red Cell Issue</u> – large rise in WM in November/December and AJ asked the group why this might be:- • Extra cases of stabbings in the WM region, which could definitely be a contributory factor. • CP of Children's hospital agreed as she had seen more children admitted with knife wounds. • Albumin peaked over Christmas period too. • Mild winter meaning not so many bed-blocker cases.	
	<u>Platelets</u> – down to 6.6% compared to kast year (but WM still third largest regional issues. Platelet wastage rising over past 2 years, AJ asked why this might be:- • Shared care – It was felt that Worcs had not commited to this • UHCW – cardiac not using many platelets any more (but using cryo instead), but still ordering.	
	<u>Cryo</u> – down to 2.4%. • Platelet changes – interruptions to agitation (red book changes) • PBM Practitioner role at NHSBT been filled. Congratulations went to Angela Sherwood, TP at UHCW who been accepted the role. Start date to be confirmed but expected to be circa 09 May 2016. Frances Sear will cover in the interim after AJ leaves on 24 March 2016.	

Any Other Business	MH: NHSBT just released an email asking for hospitals to not request their irradiated stock as HEV negative as well as the NHSBT would be unable to supply for such a high demand.	